SUMMARY OF LNF REGIONAL CONSULTATION FORUM
MINNEAPOLIS, MN
December 12-13, 2000

About this document:

This document provides a summary of proceedings of the Minneapolis consultation forum. It is not a verbatim transcript. It is a compilation of notes taken to capture the views and points expressed by participants in dialogue with members of the LNF work group who were in attendance. Approximately 65 people were in attendance. A number of people had registered, but were prevented from attending by severe weather. Workgroup members attending included Jim Crouch, Thomas John, Carolyn Crowder, Russ Vizina, Loren Ellory, and Cliff Wiggins.

Ms Rae Snider discussed tribal consultation and a flexible agenda for the consultation forums. Mentioned 40 million to distribute this FY under IHCIF and $40 million to distribute under CHS category.

Participant Comment: AThe squeakiest wheel gets the oil.@ We were funded at 31 percent, now we are at 29 percent of need. It is a good day to correct this deficiency. When the 638 law was passed our tribe was not sophisticated and did not have the resources to hire lobbyists. Many years we operate in priority one level. We are subsidizing health care with funds. Lets work together.

Participant Comment: The 10M dollars appropriated last year were to be distributed to the most needy. FY2001 Healthcare funds distributed should be recurring. Refinements to the formula should not be major. Point of clarification: a decision will be made in February and there will be no room for change after the February meeting. The National Consultation is not needed if the decision is going to be made in February. May not want to call the March meeting Consultation. Later clarified the process to assure the national meeting in March is consultation. The WG makes recommendations from its February meeting. The Director makes the decision following the March meeting.

Answer: The Director's letter announcing the San Diego consultation session states the purpose is to consult on the recommendations before a final decision is made.

Participant Comment: Questions the use of 1998 numbers as his tribal enrollment has doubled since then. The tribe funded a tribal health clinic with their funds. 100K last year but that is not enough we want some of the 30M as well. We need to look at the numbers in this formula they are outdated as they relate to our tribe. Pointed out the inequities between funding for tribes and between areas.

Answer-The workgroup has asked IHS to produce more recent user counts.

Participant Comment: the Penobscot Nation supports the USET position paper. (the paper was provided and copies will be provided to WG members) He gave an overview of the Nations position. The trust responsibility extends to all categories of healthcare funding not just personal health services. Believes this is a form of means testing regarding health care. Do not include other funding sources in the calculation of the LNF formula. The User Pop numbers are not current or correct. All users should be included in the calculation regardless of where they reside. Changes to LNF were reviewed. We shortchange our own people we shortchange ourselves.

Participant Comment: There is a need for consideration of mental health services, motor vehicle crashes. Stick to the time frames to have the funds go out quickly. Send the money recurring. The LNF workgroup has done a good job. There are some flaws, but it is the best thing we have.

Participant Comment: Understands that there was a discount given to tribes with younger populations and in their tribe they have had two young men with heart disease and an 8 year old with type 2 diabetes, there should be consideration given to their disease burden as well.

Participant Comment: What is the view of the LNF WG with regard to health status?

Answer-[Jim Crouch] It is hard to get good numbers with small populations. Health statistics are designed to track large populations. Real information from tribal sites may not truly reflect the health status unless studied over several years.

Answer-[Carolyn Crowder-AK]-concerned because other health plans look at how sick the population is and the dependency and use of the services. AK believes there may not be enough weight placed on Health status within the formula. Gave an example of problems of access.

Answer- [Tom John-USET]-believes that health status needs to be looked at as an additional measure of need. Just because similar tribes have the same funding does not mean they have the same health status.

Answer-[Cliff Wiggins-IHS]-this (health status) is our strongest argument from moral perspective. This is what will attract the attention of Congress. It should be a strong component of this formula.

Participant Comment: Request for definition the current element of health status and the changes that may be considered.

Answer-Cliff directs the group to page 4 of the LNF Primer and gives an overview.

Participant Comment: Is not a problem with the Health Status indicator. But why not use the same method the actuary used in Part 1 of the LNF study and apply it to each operating unit in Part 2 of the LNF study?

Answer-do not have data for these indicators available for each operating unit therefore three proxies were used. There is a lot of health data available in our Area is it possible you could have requested it and Areas could have provided it.

Participant Comment: What are the other health status indicators you will be considering? Answer- Death rates, birth rates, life expectancy, years of potential life lost, a variety of disease categories such as diabetes and also injuries. Local level data will be used where available, however the problem is we may not have reliable data from every operating unit. Therefore, what can we get of equal value and reliability.. The approach must be consistent and fair.

Participant Comment: Are we looking at cost of health care, the cost of transporting patients and construction of facilities? We want to ensure that every Indian is counted and that every one has the right to health care. Disagrees with the birth rates for AI/AN as being one if the highest.

Participant Comment: Responses from the LNF WG do not indicate how the formula will be used. Will it be based upon small or large tribes? Mr. Hill believes that the services that can be provided at current levels should be looked at regardless of what is provided and subsidized by tribal income. Talked about ground water contamination on his reservation and the health problems it has caused his tribal members. IHS has not appropriated funds to address this concern. The St. Croix tribe pays for the transportation and treatment for these patients. We need to sing from the same song on the same page. Tribal people are suffering because of inequitable distribution.

Participant Comment: Points out that years of productive life lost (YPLL) is not a health status indicator. YPLL will be contested very strongly. OK Area believes that deaths are not being reported accurately due to racial misclassification.

Answer-Jim Crouch brings up tape-to-tape comparison technology to address the misclassification inherent in death rate reporting. Another source is paid claims information available from HCFA. Tom John-health status needs to be take into consideration but there are problems with obtaining local data. Local data is needed to complete a true comparison. National data sets cannot be compressed into local data sets.

Participant Comment: Statement from Aberdeen Tribal Leaders Health Board was read. (Copy was added to record and will be distributed to WG members). No matter what is used as a health status indicator the problem remains that the Indian population will still be under estimated regarding health care need.

Participant Comment: will there be summary of the comments made at this meeting. Are these key points being captured and will they be made available to the workgroup members. Will they be available for each meeting?

Answer-Yes. Copies go to WG members and will be posted on LNF website by Friday.

Participant Comment: We have a lot of concerns regarding alcohol and drug abuse on our reservation. Young children are involved with alcohol and drugs and we have to remember that and find the resources to treat these people. States do not pay attention to Indian people within their states and they consistently give wrong information. We all need money but we should not have to fight one another for the money.

LNF WG views of the process:
[Jim Crouch-tribal co-chair-CA Area]-He brings up an Elephant analogy where each person touching an elephant assumes it is like the part touched (leg, ear, trunk, side,etc). The metaphor was offered to illustrate the different experiences and views coming from Indian country. While each tribe may focus on the part it knows best, in reality all tribes have have a stake in the whole system.

[Carolyn Crowder-AK Area]-She sees LNF as a means of full funding of the IHS, we can=t lose site of this. AK communities are reflected as the top standard but the standard needs to be raised the level because there are several problems in AK as well such as lack of running water and faulty construction. We need to work together to raise the level.

[Tom John-Nashville Area]-He believes that the 60 percent threshold should be raised to 100 percent. He has tried to maintain this perspective throughout this process. We need to work at increasing the size of the pie rather than fighting over the slice we have now.

[Loren Ellory-Phoenix Area]-We have a good start but this by no means the end. The formula can be improved. We finally have a platform that the Congress can understand.

Participant Comment: Appreciates the work of the LNF WG. The Congressional language begins by referencing health status. Health status begins discussion at the Congressional level and all levels. This is the key to getting new funding. Believes that the formula does not adequately take into account health status. He references Pine Ridge and their dire need. However, under the current formula this reservation gets nothing. Pine Ridge is one of the most impoverished communities in the world. How can the LNF WG ignore this. He mentions Senator Daschle and the question he may raise which is how does Pine Ridge fair in this formula and he will not like the answer.

Answer-Jim Crouch asks questions regarding Pine Ridge and the funding discrepancy. Pine Ridge is reflected at 65 percent of need but the report indicates they still need funding (15M) to reach 100 percent of need.

Participant Comment: Believes that more information can be included in the formula to truly reflect the need. He commends the Health Center Directors for doing a great job with little resources.

Participant Comment: Disputes the report and the listing of their tribe as being entitled to zero dollars. He says there services are comprehensive but they still have an unmet need. Will this formula be used to allocate funds other than IHCIF? Our tribe has been successful

but should not be penalized for that. The issue still lies between the federal government and the Red Lake government. We have to stick together and ask for the 100 percent.

Answer-Jim Crouch he does not believe that any other funds will be distributed utilizing the LNF methodology just IHCIF.

Participant Comment: references the August 24 letter from Dr. T where the tribe was identified as being funded at 29 percent of need. Mr. Hill reviews the key points of the letter. He mentions utilizing Congressional people to get funding allocations, but this only works for those tribes who are sophisticated and he supports them. He is going to go testify regarding his need and to ask the federal government to fulfill its trust responsibility. He believes the cap should be lowered to 40 percent so that the priority shifts even further to the most needy tribes.

Participant Comment: She wants to point out a misconception that if you have a facility then your need is not as great, but some of the facilities are so outdated and in need of repair. Also, facilities are counted in the formula which downplays the level of need.

Participant Comment: Choctaw Nation has a 6M denial of CHS services last year even though they do have a hospital and clinics. There is still a need.

Participant Comment: Appreciates the LNF WG hard work but is going to criticize it. IHS and the Federal Government have a tendency to use formulas and other tools and fit them into boxes they were not intended for. Such as the user pop numbers which two workgroups have found the numbers to be inaccurate. Additionally, the user pop numbers were collected to study disease not allocate funding. However, the IHS continues to use these numbers in funding allocation formulas even though they are not accurate. This should stop.

LNFWG Response
[Jim Crouch] responds by stating that he admits if you continue to use the frying pan as the hammer you are not going to drive the nails in as straight but you can not let the lack of a hammer impede the process. He considers user pop as a suitable replacement but accepts that this cannot continue and he looks forward to the day when we have perfect data.

[Carolyn Crowder]-does not want to lose the value of the point of the criticism. She says that the LNFWG did send a letter to Dr. T. explaining that user pop numbers is not accurate but it is readily available.

[Tom John]-believes that user pop has merit at the Area level but not tribe to tribe. He brings up the fact that FY98 numbers are being used and it is FY01. He is looking to the tribal leaders for direction in what should be done.

[Cliff Wiggins]-does not take the comment as a criticism but a valid point shared by others. Trying to find data representative of individual tribal communities is hard because it is not available. The LNFWG looked at approaching the task from an Area perspective but the law references individual Indian Communities. He looks to the group to give the LNFWG ideas for

improvement.

[The group agrees to stay together and not continue in break out sessions.]

Three groups of topics will be discussed in more detail. They are: 1) Health Status 2) Inclusion Level 3) Data

Participant Comment: references Healthy People 2000 report sent by DHHS and notes that the IHS was not included in the acknowledgments nor did he recognize any of the names in the report as being from IHS. Where is the Indian population addressed why aren=t we included? Where was the IHS leadership when the DHHS Secretary was developing Healthy People goals and objectives? He notes they have some good goals and objectives.

Answer-The Surgeon General and likely the Public Health Policy Council were responsible for development. Ms. Snyder would have to check to see what the level of participation of the IHS was. The draft report was sent to the agency and it is likely the response came from the Office of Public Health.

Participant Comment: Reauthorization of the Indian Health Care Improvement Act (IHCIA) and the need to look toward the future.

Participant Comment: He has been watching the news and is scared of the Republican Administration and tendency to look towards means testing. If means testing is instituted then Indian Tribes will not fair well. Indian Tribes need to be prepared for what may happen with either administration. Will Dr. Trujillo remain after the new administration takes office?

Ms. Snyder is a schedule C employee and she serves at the pleasure of this administration. Dr. Trujillo has a term appointment that was Senate confirmed. He is not required to submit his resignation as Ms. Snyder is. Dr. Trujillo is committed to serve the two remaining years of his term.

Health Status Discussion

Participant Comment: Disease prevalence might be okay, including diabetes, cardio vascular, and alcohol substance abuse. Those priorities identified by the budget formulation team. Sub-sets of these diseases would be allowed including amputations. Would not support using YPLL or Death rates due to non-applicability to health status and racial misclassification, respectively.

Participant Comment: references diabetes and the need for 200M identified by the IHS Budget Formulation WG. Is this not an indicator that our health status is poor? Can this be translated into a need?

Participant Comment: Tribal health care is at a critical stage. We are funded at 36 percent of need according to LNF, but she thinks this should actually be lower. Does not believe that third party resources should be taken into account in this formula. What little funding they

do make goes right back into CHS. If you were to send out a check each individual at their tribe would receive 23 dollars for dental and 284 dollars for health.

Participant Comment: Tribal health care is at a critical stage. $ 474K is already spent for fiscal year 2000 they have approximately 3000 left until July. They are seeing different diseases happening to a younger population. They experienced seven heart surgeries in one month. Their diabetes funds are in jeopardy and they haven=t received the new application. The issue of urban rural costs does not apply-costs the same when you must purchase care with CHS dollars.

Answer-Cliff responded that the WG has changed some elements including allowing Area Office staff to work with Operating units to identify price factors for locations where most referrals are made.

Participant Comment*: Asked for more detail about the health status factor in the current methodology and proposed raising the "weight" of health status to 200%.*

Answer-Cliff responded with a flip chart example:

$2,500 per person IF AIAN were equally healthy as other Americans
+500 per person added by the Actuary based on national averages for health of Indians
$3,000 per person benchmark on average for all AIAN

The health status indices show variations among areas in Indian health status. These indices were used to adjust the +500 add-on for each Area. The add-on might be $750 per person in areas where health was especially poor. It might be $250 per person in areas where health was better than the IHS average.

In this example, the proposal to double the weight of the health status adjustment would change the math as follows:

$2,000 baseline amount
+1,000 add-on for poor health of AIAN (average)
$3,000 per person benchmark remains the same to be consistent with overall LNF findings.

The differential add-ons based on the health status indices would change from $250 to $500 for areas with better health and from $750 to $1500 for places with worse health status.

Participant Comment: states that Choctaw has never been asked the question directly.

Answer-Cliff states the Areas will be asking for this information during the new application of the methodology. This is a change from the 2000 application of the methodology.

Participant Comment: gives an overview of the Aberdeen Area position regarding the use of health status and support for a weight factor of 200 percent.

Participant Comment: states that the RPMS needs to be looked at because they get messages that their transmissions go through successfully only to find out much later that the information was not retrievable. User population numbers are unreliable when pulled from RPMS due to transmission problems. We try to get through the Area office but are not successful they can=t get through to the person they need and they leave messages that are not returned.

Participant Comment: questions information in the AK Area position

Participant Comment: Where do you get 2980 at our tribe? We did a feasibility study that said we get less than that (225/person for CHS). If we got the 2980 we would be blessed. We are one of the top eight lowest funded operating units in the IHS. He is thinking of going to Las Vegas to bring the statistics of how much the tribe subsidizes their health care. He is discouraged that the IHS is not living up to its trust responsibility.

Answer-Jim Crouch-the fact is the IHS budget has grown by 36 percent over the course of six years but if you factor in inflation and population growth the increase is only 2 percent. The biggest issue at hand is # persons served, health status and the numbers being utilized for calculation-we are two years behind in data and it is a large concern.

Participant Comment: Clarification, 2980 is the amount of funding we are looking at receiving but that figure changes. The unmet need level is not true because we need more than what that 2980 represents.

Answer-cost of wrap-around services are separate and are not included.

Participant Comment: Birth and death rate are looked at. In CA the death rate for 15-20 year olds may be motor vehicle crashes but in OK the death may be from diabetes and heart disease. The cost for OK will be greater than for CA in this scenario. There are differences in what makes up health status from Area to Area. There is a disparity in the cost of treatment and the length of treatment required for different diseases.

Participant Comment: He agrees, but if you begin to place weights on different components of the formula, he warns that consensus will never be reached and the process could be time consuming.

Participant Comment: Observes that if Congress had intended the formula to be based upon population alone, then the job would be easier, but they used Health Status in the appropriation language. He believes that because of this Health Status should be weighted more heavily. How are you going to come up with which health categories should be included and measured? He is concerned that the health problems are very different from tribe to tribe. He cautions using the National Budget priorities and recommends using the Area submissions to Headquarters.

Participant Comment: The Little Shell Band are in the process of receiving Federal Recognition and some of their members live on the Ft. Belknap reservation and are

intermarried with Ft. Belknap members. Their recognition will affect Ft. Belknaps user numbers and she believes they should be included in this formula due to their use of the system.

Participant Comment: The one issue that isn=t addressed in this formula that needs to be addressed somewhere is water sanitation and environmental health. They are seeing occurrences of auto-immune diseases due to water contamination. Have a lot of Lupus diagnosis. They are considered a hot spot for cases of Bells Palsy.

Participant Comment: Understands using the Federal Employees Health Benefits (FEHB) package as an starting point. Using the health status is appropriate due to the low health status as an indicator. She does not agree that health status should be weighted more that any other component, that action would move away from the FEHB as a basis for LNF.

Inclusion Level Discussion:
WG wants input at setting the threshold for participating in the FY 2001 IHCIF—40%, 60%, 80%, 100%.

Clarification by Tom John that these numbers are for personal health services only that deficiencies still exist in the areas of wrap around services.

[Jim Crouch]-points out that the higher the percentage the longer the list and the more stretched out the funding goes.

Participant Comment: mentions consideration should be given to using a graduated method of distribution ie. 50 % of IHCIF $ to those below 40% LNF, 20% of $ to those up to 60% LNF, and the remainder of $ to those above 60% LNF.

Participant Comment: can=t reiterate enough that the intent of Congress is to design a methodology to distribute funds to the most needy tribes.

Participant Comment: references the need as identified by the Budget Formulation workgroup as being $8,billion. If you look at this figure then all of the tribes are under funded.

Participant Comment: recommends the threshold be set at 65 percent.

Participant Comment: references the graduated approach to distribution of funds as explained by Carolyn Crowder. Similar to the way CSC was distributed. He thinks this would be more palatable to all tribes.

[Jim Crouch]-politically we have to reach at least half of the operating units with the funds. The IHCIF is only one of line items funded per year. If all of the new funds appropriated for the IHS were being distributed using this formula he would advocate for inclusion of all operating units. Inflation costs should be met everywhere prior to discussing inequity. References Dr. Rhodes philosophy of Ado no harm@.

[Cliff Wiggins] references page six of the LNF Primer and the pie chart that shows the FY 2001 IHS budget. He gives an overview of the pie chart and relates to increases.

Participant Comment: IHS HQE-how does the minimum proposal relate to the Tribal Size Adjustment?

Answer-Cliff the CSC formula is more closely related because it distributes funds to all parties using a proportion of deficiency approach. The difference is that CSC is available for about 90 cents per dollar of need, where as the IHCIF is only about 4-5% of deficiency.

Participant Comment: concerned that if we follow the approach setting the distribution target at 60%, then they would not get any funding for years.

Participant Comment: politically it will be better to give some money to many tribes in order to get support.

Participant Comment: He appreciates the difficult job that the LNF WG has to complete. He asks them not to lose site of the Congressional intent of the appropriation that uses language like "tribes with the greatest health status and resource deficiency".

Participant Comment: Will the things said here be carried forward to Las Vegas and DC.

Answer-yes there will be a synopsis, but the same issues may be discussed again due to the presence of a new audience.

Participant Comment: will the LNF workgroup be setting up front with Dr. Trujillo during the San Diego meeting?

Answer-have not decided that yet, but is open to suggestions.

Data Discussion:
Modifying the definitions for users, use more recent data, additional data regarding users outside of the CHSDA, quality of the data in all locations.

Cost Indexes-use of county data vs. tribally driven data

Participant Comment: References page five of the LNF Primer where IHS funds available are identified. She is not sure about how facilities 40 years and older are accounted for. ie. Pine Ridge facility is listed as having received 16M dollars for a new facility in the 1990s. Is she reading this correctly? I do not understand this piece on facilities.

Answer-A typical depreciation approach was used. This means that approximate 400K ($16m/40years useful life of a facility) was counted for Pine Ridge.

Are these just federal facilities and are tribally owned and built facilities included?

Answer-tribally contributions are not included when they finance facility construction from tribal resources.

[Jim Crouch] it seems that those tribes who have debt service costs they should receive a deduction of the cost they incurred to build their facility. The servicing of the debt should be addressed as an unusual cost. There was extended discussion to treat all fairly whether by depreciation, debt service, or rent.

Participant Comment: built a facility with their own funds without incurring debt same as the Choctaw Nation.

Participant Comment: Are tribal resources included or not – what does the statute say.

Answer-they are not included in the statutory language and there is virtually 100 percent opposition to inclusion of tribal resources. The statutory language says all federal funds ie. M/M collections, state funding, and private insurance.

[Tom John]-mentions that the IHCIA and Title V of the ISDEAA have statutory language that says the collections and tribal resources cannot be used to off-set funding available to serve AI/AN people.

Participant Comment: Explain the rational for including facilities as a resource? Are all the cost related to facilities included in the formula?

Answer-there is a line by line budget including facilities line items. Facilities construction amounts are not included directly. Rather, the construction amount is depreciated over the life of the facility and that annualized amount is included as funds expended annually. But the OEH&E line items for sanitation and other purposes unrelated to the benchmark benefits package are not included. Equipment and facility maintenance line-items are related to the benefits package to the extent facilities are used for personal medical care, about 89% on average. So 89% of these funds are included.

Participant Comment: disagrees with Mr. Crouch and his belief that many patients are going to several facilities but should only be counted at one operating unit. A-Jim Crouch explains that the patient may only go to one facility for minimal problems and another for major problems. Mr. Grimm disagrees with the amount used to adjust for collection activity.

Participant Comment: If the tribe pays base service ie. the Chickasaws service a lot of Creek members but the tribes pay for those visits so then where do these patients get counted.

Answer-the Areas conduct this analysis and adjustments are made at that level. Q-what about the Veterans Administration? A-they are included in the $745 global estimate of non-IHS coverage.

Participant Comment: does not believe that the Choctaw Nation should be penalized for building their own facility rather than wait for twenty years. Also, only current resources

should be counted do not include the IHCIF funds received last year because they were distributed non-recurring.

Answer-Cliff explains that reporting guidance for FY 2001 requires non-recurring $ to be shown as part of the "area-wide" amount so it will not penalize the Operating Units. Jim Crouch explains using a Tribal Organization who has taken available shares then this gets credited to the operating unit.

Participant Comment: mentions the deficiency column and recommends that it should be deducted from the depreciation line item prior to applying it to the LNF formula.

Answer-Cliff states that is a good question and that piece has not been considered thus far.

Participant Comment: Would you consider subtracting the backlog of facility repairs deficiency from the depreciation?

Answer-Jim Crouch says the LNFWG will look at this. Cliff-says that in some cases we may find that the depreciation for a facility may be 7M but the deficiency is 10M therefore the asset is actually a liability.

Meeting adjourned at 5:10 p.m.